Principles underpinning optimal cancer care
Patient-centred care, Safe and quality care, Multidisciplinary care, Supportive care, Care coordination, Communication, Research and clinical trials

Pandemic phase incorporating changing health system capacity and pandemic progression	**Steps of the cancer care continuum**						
	Prevention and early detection	**Presentation, initial investigations and referral**	**Diagnosis, staging and treatment planning**	**Treatment**	**Care after initial treatment and recovery**	**Managing recurrent, residual or metastatic disease**	**End-of-life care**
Acute Phase I Semi-urgent setting. Few pandemic infection patients and numbers not rapidly escalating, demand within health system capacity.	Continue population-based cancer screening with appropriate social distancing.[1,3]	Continue initial investigations with use of telehealth where possible*; encourage community members to present to GP with 'red flag' symptoms of cancer.	Prioritise diagnostic procedures for patients with symptoms and test results suspicious for cancer and utilise telehealth where possible*.[6,7]	Determine if surgery is elective (can be delayed without a predicted negative outcome);[8] consider modifications to radiotherapy (e.g. hypofraction-ation)[9,10] and to systemic treatments (e.g. oral, shorter regimens).[11,12]	Consider shared follow-up care, utilising telehealth where possible*;[11,13] screen patients for distress and provide psychosocial support.[12]	Consider modifying treatments for patients with refractory/ resistant disease; or treatment breaks for patients with low-volume and/ or stable metastatic disease.[12]	Consider utilising telehealth[14] and community palliative care services[12] where possible*; discuss goals of care and advance care planning.[12,15]
Acute Phase II Urgent setting. Rapidly escalating numbers of pandemic infection patients, approaching limits of health system capacity.	Consider reduction of routine population-based cancer screening according to resource availability[2,3,6] but for the least possible time during prolonged acute phases. Follow up abnormal screening results in patients already screened, prioritising those highly suspicious for cancer.[6]	Continue initial investigations with use of telehealth where possible*; encourage community members to present to GP with 'red flag' symptoms of cancer.	Prioritise diagnostic procedures for patients with symptoms and test results suspicious for cancer and utilise telehealth where possible*.[6,7]	Prioritise surgery patients by urgency;[6,16] consider delay in commencement of radiotherapy unless urgent;[6,9] modify systemic treatment as feasible (e.g. oral or less toxic regimens).[11,12,15,17] Limit patient visitors or support persons in hospitals (except at end-of-life).	Delay face-to-face follow-up appointments and utilise telehealth where possible*;[11] consider innovative models of care e.g. shared follow-up care with GP; screen patients for distress and provide psychosocial support.[12]	Minimise commencement of IV treatment for patients with refractory/ resistant disease; consider deferring palliative radiation therapy treatments[18], except where these are for life-threatening or urgent conditions.[9] Limit patient visitors or support persons in hospitals (except at end-of-life).	Consider utilising telehealth[14] and community palliative care services[12] where possible*; discuss goals of care and advance care planning.[12,15]
Acute Phase III Emergency setting. High numbers of pandemic infection patients, health system capacity exceeded.	Consider reduction or deferral of routine population-based cancer screening[2,3,6] but for the least possible time during prolonged acute phases. Follow up abnormal screening results in patients already screened, prioritising those highly suspicious for cancer.[6]	Appropriately investigate and refer patients with symptoms, with use of telehealth where possible*; encourage community members to present to GP with 'red flag' symptoms of cancer.	Prioritise diagnostic procedures for patients with test results highly suspicious for cancer and utilise telehealth where possible*.[6,7]	Prioritise surgery for life-threatening conditions;[6,16] defer or avoid radiotherapy if clinically appropriate and use shortest safe regimen;[6,9,10] discuss risks and benefits of starting or changing systemic treatment and reach a shared decision.[11,19] Limit patient visitors or support persons in hospitals (except at end-of-life).	Delay face-to-face follow-up appointments and utilise telehealth where possible*;[11] consider innovative models of care e.g. shared follow-up care with GP; screen patients for distress and provide psychosocial support.[12]	Minimise commencement of IV treatment for patients with refractory/resistant disease or palliative regimens with a low likelihood of response/benefit; if radiotherapy is needed for symptom control, use the shortest safe form of treatment.[9,14] Limit patient visitors or support persons in hospitals (except at end-of-life).	Consider ceasing palliative treatments that have minimal chance of substantial benefit; prioritise management of patients with urgent symptomatic need;[6,14] discuss goals of care and advance care planning.[12,15]
Recovery Phase Past the peak of pandemic infection with fewer new daily cases, health system capacity not exceeded.	Considerations for reintroduction of services should include the local levels of pandemic infection transmission, the local or regional health system capacity and availability of resources. These considerations may change over time and vary by service type and setting.[2,6] Gradually reintroduce the standard of care according to perceived risk, prioritising patients at high risk (such as those most at-risk for complications from delayed care, or those with high risk of cancer progression or recurrence) with consideration of each individual patient's risk of exposure to the pandemic infection due to the resumption of care.[2,20]						
	Gradually reintroduce routine population-based cancer screening with consideration of local conditions and resource availability.[2,6] Prioritise appointments for participants whose screening appointment was delayed or for high-risk patients.[2]	Appropriately investigate and refer patients with symptoms; encourage community members to present to GP with 'red flag' symptoms of cancer.	Prioritise diagnostic procedures for patients with test results highly suspicious for cancer and utilise telehealth where possible*.[6,7]	Gradually reintroduce routine surgery up to capacity limits and prioritise high-risk patients and patients whose surgery was delayed due to the pandemic;[6] continue hypofract-ionation where appropriate;[16,18] commence or re-start as appropriate, adjuvant treatment that was deferred or interrupted.	Prioritise follow-up appointments (as well as any hospital imaging and/or blood tests) for high-risk patients and patients whose appointments were delayed during acute pandemic phases.[2]	Gradually reintroduce standard of care according to perceived risk, prioritising high-risk patients, depending on the environmental circumstances and each individual patient's risk of exposure to the pandemic infection due to the resumption of care.[2,20]	Gradually reintroduce standard of care according to perceived risk, prioritising high-risk patients, depending on the environmental circumstances and each individual patient's risk of exposure to the pandemic infection due to the resumption of care.[2,20]

Vaccination, if vaccination against the pandemic pathogen is available, should be offered to cancer patients, with consideration of any vaccine contraindications, type of cancer, type and timing of treatment and level of immunocompromise.[21-24]

* For telehealth services, videoconferencing is the preferred substitute for a face-to-face consultation.[4,5]

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